HEALTH INSURANCE **APPLICATION FORM**
SALUS GLOBAL HEALTH

APPLICATION Nº: **POLICY Nº:**

DETAILS OF POLICY HOLDER

SURNAME(S):_____NAME:_____
N.I.F./PASSPORTNº_____NACIONALITY:_____LANGUAGE:_____
DATE OF BIRTH _____/_____/_____TELEPHONE Nº: (+34)_____MOBILE PHONE: (+34)_____
ADDRESS:_____POSTAL CODE :_____
TOWN:_____PROVINCE:_____EFFECT DATE:_____
COMMUNICATIONS ADDRESS: _____
EMAIL: _____

Residence certificate application YES ☐ NO ☐

The information collected complies with the provisions of article 175.1 of the Insurance Distribution Law regarding the obligation to determine the demands and needs of the client prior to the conclusion of an insurance contract.

DISTRIBUTION CHANNEL

Colaborator (Agent):_____Agent Code _____

DETAILS OF THE INSURED

1	**Name & Surname(s)**	**Policyholder**	**Date of birth**	**Nationality**	**ID**	**Gender**
	Mobile Phone		**Email**			
	Address of country of origin (in case of repatriation) ☐ **Rights to repatriation waivered**					
2	**Name & Surname(s)**	**Relationship**	**Date of birth**	**Nationality**	**ID**	**Gender**
	Mobile Phone		**Email**			
	Address of country of origin (in case of repatriation) ☐ **Rights to repatriation waivered**					
3	**Name & Surname(s)**	**Relationship**	**Date of birth**	**Nationality**	**ID**	**Geder**
	Mobile Phone		**Email**			
	Address of country of origin (in case of repatriation) ☐ **Rights to repatriation waivered**					
4	**Name & Surname(s)**	**Relationship**	**Date of birth**	**Nationality**	**ID**	**Gender**
	Mobile Phone		**Email**			
	Address of country of origin (in case of repatriation) ☐ **Rights to repatriation waivered**					

Total Annual Premium:_____ €

INFORMATION FOR THE POLICY HOLDER / INSURED

Information clausel and consent regarding General Data Protection Register (GDPR)
The responsible party for handling your data is SALUS ASISTENCIA SANITARIA, S.A. DE SEGUROS. Your data will be used to carry out the management and processing of insurance and provide health insurance as derived from your data, and they will as well be used to as carrying out the contractual management for the insurance company with its Customers / Policyholders / Clients. For the purposes indicated above and in order to ensure the best compliance and management of our services, policyholder and / or beneficiary of the insurance grant their express consent freely and voluntary for their data, which has provided by themselves, to be handled and preserved by the insuring party.
You are being informed that in order to be able to execute your insurance, your data may be transferred to other insurance companies due risk of reassurance and co-assurance.
The beneficiary of the insurance authorizes the professionals, clinics and hospitals of the insurance company to request provision of personal data and specifically health data of the insured for the assessment of the risks to be covered, prevention of fraud, attending to complaints, management of the contracted insurance and other healthcare service offerings.
Legitimacy for using the data of the insured is based on the execution of a contract. Except the in the cases of legal obligation, no data will be transferred to third parties. The data of the insured will be destroyed once the contract termination is notified and / or the legal preservation periods have ended, which in this case is 10 years. There will not be any international data transfer.
The insurance company undertakes the responsibility of maintaining confidentiality of the personal data provided and guarantees to maintain the technical and organizational measures obligated by the data protection regulations in order to avoid their alteration, loss, treatment or unauthorized access, notwithstanding that said data, or access to the file containing the mentioned data may be provided to bodies or entities that are legally entitled.
Insured or the beneficiary of the insurance will in all cases be responsible of the truthfulness of the data provided, with the insurance company reserving the right to exclude any person or entity that has provided false or missing data from its services, regardless other legal proceedings that may be processed.
It shall not be possible to provide our services without the data subject to treatment, which is necessary for the purposes indicated beforehand. In case of opposing of treatment and / or transfer of the data contracting the insurance or provision of the services shall not be possible.
Interested parties may use their right regarding access, rectification, deletion, opposition, portability or limitation of data handling by contacting SALUS ASISTENCIA SANITARIA S.A. INSURANCE at the following address: Calle Posada Herrera 1 Bis 1st OVIEDO 33002 ASTURIAS or email protecciondatos@salus-seguros.com. You may also revoke the consent given by sending your written notice to above address. Additionally, you can file a complaint to the Spanish Data Protection Agency if you think that your rights have been violated. You can contact the Delegate of Data Protection by sending a written notification to dpdasturias@prodat.es.
Express consent is required for the rest of the proceedings.

ANNOUNCEMENTS:

Send me advertisement communications through sms, email, mail or other means in order to be informed regarding the services offered by the company. YES ☐ NO ☐

Send me personalizaded communications through sms, email, mail or other means in order to be informed regarding the services offered by the company. YES ☐ NO ☐

In _____, the _____ of _____, _____.

Signature: **THE POLICY HOLDER**

SALUS
HEALTH INSURANCE

HEALTH **DECLARATION**

INSURED

Name and Surname: _____

DNI/NIF/PASSPORT NUMBER: _____ Date of Birth: _____ / _____ / _____

Male ☐ Female ☐ Weight:_____ Height: _____ Blood pressure (max / min): _____

Do you smoke? Yes ☐ No ☐ Do you drink alcohol? Yes ☐ No ☐ Do you have social security? Yes ☐ No ☐

If "yes", please give a brief description, stating the type and amounts consumed:

1. Do you currently have any illnesses? Yes ☐ No ☐
If "yes", please explain

2. Do you have any undiagnosed symptoms or pain? Yes ☐ No ☐
If "yes", please explain

3. Are you currently under the care of a doctor? Yes ☐ No ☐
If "yes", please explain

4. Do you take any medications? Yes ☐ No ☐
If yes, state the name, dose, reasons, and the specialist is following you

5. Have you ever been treated in a hospital or clinic for an illness, surgery, or an accident? Yes ☐ No ☐

If yes, state the date of diagnosis and consequences (you need not to include the operations or procedures described below, unless there were sequelae or complications: angina operation, vegetation, appendectomy, childbirth, caesarean section, curettage, phimosis, vasectomy, tubal ligation, sebaceous cysts, lipomas, surgical extraction of mandibular third molars, minor ophthalmic surgeries, etc.).

6. Do you have or have suffered from any physical defect, deformity, disability, or congenital alteration, with sequelae? Yes ☐ No ☐

7. Have you had any injuries or accidents? Yes ☐ No ☐
If "yes", indicate any sequelae

8. Have you undergone any diagnostic or therapeutic tests in the past five years (Scanner, Nuclear Magnetic Resonance, Ultrasound, Colonoscopy, Gastroscopy, Scans, Holter, Doppler etc.)? Yes ☐ No ☐
If "yes", please explain the reason

9. Have you had any rehabilitative treatment in the past five years? Yes ☐ No ☐
If "yes", please state which and why.

10. Do you have any diagnostic tests, therapies, rehabilitative treatment, hospital admission, or surgery pending? Yes ☐ No ☐
If "yes", please explain

11. Do you have or have you had any psychiatric or psychological disorders? Yes ☐ No ☐
If "yes", please explain

12. Are you pregnant? Yes ☐ No ☐

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You are being informed that in order to be able to execute your insurance, your data may be transferred to other insurance companies due risk of reassurance and co-assurance.
The beneficiary of the insurance authorizes the professionals, clinics and hospitals of the insurance company to request provision of personal data and specifically health data of the insured for the assessment of the risks to be covered, prevention of fraud, attending to complaints, management of the contracted insurance and other healthcare service offerings.
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Send me personalized advertisement communications through sms, email, mail or other means in order to be informed regarding the services offered by the company. Yes ☐ No ☐

In _____, _____ of _____, _____

Signed: THE INSURED THE POLICY HOLDER (only in case of insured minors)